STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

DEC 2 9 1999

Mr. Dan McCarthy
Health Care Financing Administration/CMSO
Mail Stop S2-03-08
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Mr. McCarthy:

This is an amendment to the State of Iowa's Children Health Insurance Program, Healthy And Well Kids in Iowa (HAWK-I) program. This amendment includes an additional managed health care plan, Unity Choice from Wellmark Health plan of Iowa and allows for a 20% deduction to earned income in determining eligibility for the HAWK-I program.

If you need further information or have any questions, please call Anita Smith at 515-281-8791 or Anna Ruggle at 515-281-4186. Thank you.

Sincerely,

Jessie K. Rasmussen
Director

Enclosures: Amendment
Iowa Map
Unity Choice Evidence of Coverage

CC: Tom Lenz
Associate Regional Administrator
Division of Medicaid and State Operations
601 E. 12th St., Room 227
Kansas City, MO 64106

Section 1. Amendment to the State Plan. The State Plan is amended and supplemented as follows:

1. Section 4. Eligibility Standards and Methodology. (Section 2102(b)); subsection 4.1.1 shall be deleted and the following language substituted:

4.1.1 Geographic area served by the plan: The state has been divided into six regions for the purpose of establishing plan participation. (Refer to Attachment "S") If a health plan wants to provide coverage in any county within a region, it must be provide coverage in every county within that region in which it is licensed and has a provider network established. Under HAWK-I, managed care plans can only provide services in those areas of the state in which they are licensed and in which a provider network is established.

Effective October 1, 1999, two managed health care plans, Iowa Health Solutions and Unity Choice from Wellmark Blue Cross Blue Shield are providing coverage in the following Iowa counties:

Iowa Health Solutions only:

Calhoun	Dubuque	Lee	story
Clayton	Hamilton	Louisa	Van Buren
Clinton	Hardin	Marshall	
Des Moines	Jackson	Muscatine	

Unity Choice from Wellmark Blue Cross Blue Shield only:

Black Hawk	Carroll	Delaware	Johnson	Pottawattamie
Bremer	Cedar	Fayette	Jones	Shelby
Butler	Clarke	Grundy	Madison	Washington
Cass	Dallas	Iowa	Montgomery	

Iowa Health Solutions and Unity Choice:

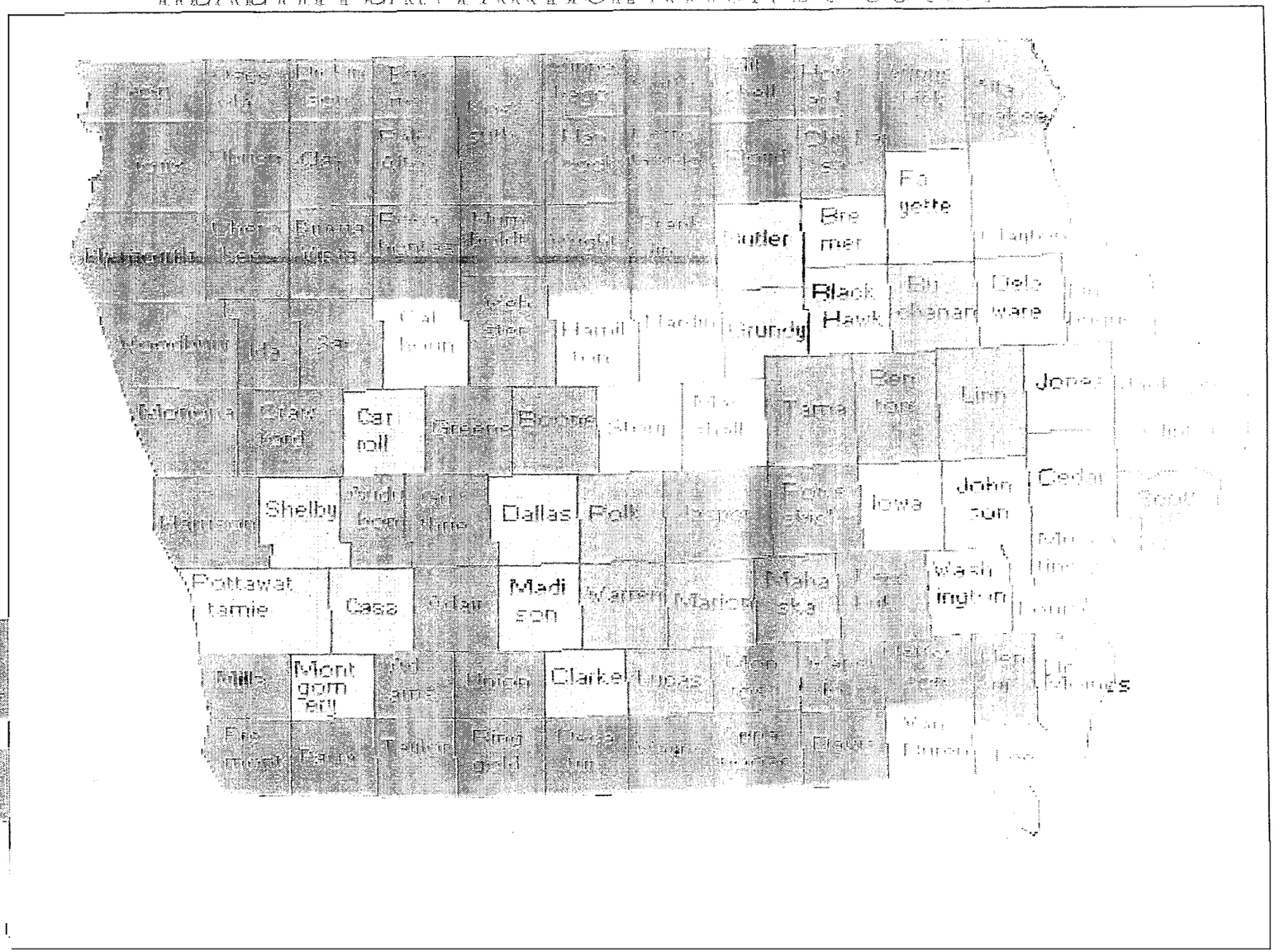
Benton	Linn	Marion	Tama
Boone	Lucas	Polk	Warren
Buchanan	Mahaska	Scott	

Wellmark Blue Cross Blue Shield Classic Blue, an indemnity plan provides coverage in the remaining 55 counties of the State.

2. Section 4. Eligibility Standards and Methodology. (Section 2102 (b)), subsection 4.1.3 shall be deleted and the following language substituted:

4.1.3 Income: Under HAWK-I, countable earned and gross unearned income cannot exceed 185% of the federal poverty limit for a family of the same size. Effective December 1, 1999, 20% of earned income (including self-employment income) will be exempt when determining family income for the HAWK-I program.

HEALTH PLAN PARTICIPATION BY COUNTY



Attachment S

UNITY CHOICE@

HAWK-I

Group Effective Date: 9/1/99
Print Date: 8/27/99
Coverage Code: VVF, VVG
Form **Number: IA WHPII Unity Hawk-I**

Version: 9/99

ENROLLEES' RIGHTS AND RESPONSIBILITIES

All Wellmark Health Plan of Iowa, Inc., enrollees have a right to:

- receive accurate information about the health plan, its services, its participating providers, and its enrollees' rights and responsibilities;
- be treated with respect, in a manner that preserves their dignity and recognizes their right to privacy;
- participate fully, with their providers, in decision-making that affects their health care;
- expect a candid discussion of all appropriate ***or*** medically necessary treatment options pertaining to their condition, regardless of cost or benefit coverage; and
- voice complaints about the health plan or the care delivered by any of its providers.

Likewise, Wellmark Health Plan of Iowa, **Inc.,** enrollees share responsibility for maintaining their own good health. Specifically, all Wellmark Health Plan of Iowa, Inc., enrollees have a responsibility to:

- provide, to the extent possible, information that the health plan and its providers need in order to care for them; and
- follow the plans and instructions for care that they have agreed to with their providers.

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COPAYMENT

Copayment is the fixed dollar amount you pay each time you receive certain covered services.

Emergency Room Copayment

Emergency room copayment is the fixed dollar amount you pay each time you visit an emergency room when your condition is not an *emergency,* as defined in the GLOSSARY at the end of this policy. Your emergency room copayment is:
$25 per visit. This amount includes all related services.

This copayment is waived if

- your condition is an *emergency,* as defined in the GLOSSARY at the end of this policy; *or*
- you are admitted as an inpatient immediately following emergency services; *or*
- you do not pay a premium to the third-party administrator.

SERVICE LIMITATIONS

Certain covered services are subject to dollar or time limitations, which are called *service limitations.* This policy includes service limitations for the following services:
Dental Treatment For Accidental Injury must be completed within three months ***of*** the injury.
Transplants:

$20,000 per bone marrow/stem cell transfer for costs associated with a donor search
$10,000 per transplant operation for costs associated with an enrollee's transportation in an ambulance to a transplant center
$20,000 per transplant operation for costs associated with organ procurement of cadaveric organs, even if more than one organ is transplanted. ***Please note:*** This organ procurement limitation does not apply to organs donated by a living donor (i.e. bone marrow/stem cell transfers, livers, and kidneys donated by a living person) and organ transplants received in a facility that agrees to accept global pricing arrangements. For a definition of *global pricing arrangements,* see the GLOSSARY at the end of this policy. For more information about whether a facility accepts global pricing arrangements, call us at **1-800-785-7480.**

BENEFIT PERIOD MAXIMUM

Benefit period maximum is the maximum benefit each enrollee is eligible to receive for specific services during a benefit period. You have the following benefit period maximums:
Five self-referred visits for chiropractic care from a Unity Choice Network chiropractor
30 days for the *inpatient* treatment of mental health conditions and chemical dependency
30 visits for the *outpatient* treatment of mental health conditions and chemical dependency
One routine vision examination.

LIFETIME BENEFITS MAXIMUM

The maximum amount each member is eligible to receive for covered services in his or her lifetime is called the lifetime benefits maximum. The lifetime benefits maximum is accumulated from claims settled under this policy issued to you by Wellmark Health Plan of Iowa, Inc. Your overall lifetime benefits maximum is **$1,000,000** and includes maximums for the following services:
15 days of ***inpatient*** hospice respite care
15 days of *outpatient* hospice respite care
Please note: Hospice respite care must be used in increments of not more than five days at a time.
Two programs for diabetic education.

SUMMARY OF PAYMENT

Your health care coverage is called ***Unity*** Choice. It features some of the latest concepts in health care delivery which are designed to provide you quality health care coverage at an affordable cost. One of the most important features of Unity Choice is your primary care provider. A primary care provider acts as your personal health care manager. Your primary care provider will evaluate your medical condition and either treat your condition or coordinate health care services that you require. With his or her advice and guidance, you will have access to comprehensive health care coverage.

USING THE UNITY CHOICE PROGRAM

■ UNDERSTANDING PROVIDER TYPES

We use the word provider to mean a physician or other practitioner who provides you with health care services. Your provider may also be the place or source where you receive services, such as a hospital or nursing facility. Additionally, your provider may be a supplier of health care products, such as a home/durable medical equipment supplier.

Providers in the Unity Choice Network are committed to working with you and with us to help contain costs and provide quality health care coverage. For specific Unity Choice network provider names, check your *Unity Choice Provider Directory*. If you did not receive a copy or you lost your copy, or if you wish to obtain information about provider credentialing, call **1-800-892-2397.**

■ UNDERSTANDING THE ROLE OF YOUR PRIMARY CARE PROVIDER

Your primary care provider is your key to receiving benefits under this program. Generally, to receive benefits, you must receive care from or coordinated by your primary care provider. For circumstances in which you do not need to contact your primary care provider, see *Getting the* Most *Out of Your Coverage* later in this IMPORTANT INFORMATION section.

Choosing Your Primary Care Provider. Each member must choose a primary care provider from the Unity Choice Network when you enroll.

We urge you to develop a close relationship with your primary care provider. Following his or her advice will assist him or her in providing you appropriate and cost effective medical services.

If your primary care provider leaves the Unity Choice Network, we will notify you by mail. You must then choose another primary care provider in the Unity Choice Network who will provide or coordinate care.

Choosing Your Obstetrical/Gynecological (OB/GYN) Care Provider. Your primary care provider may provide gynecological and maternity care or you may select an obstetrical/gynecological (OB/GYN) care provider from the Unity Choice Network for your gynecological and maternity health care. Each female enrollee may choose her own OB/GYN care provider. When you need gynecological or maternity care, you may contact either your primary care provider or your selected OB/GYN care provider and receive benefits. If a female enrollee does not select an OB/GYN care provider, however, this care must be provided by or coordinated by her primary care provider.

Please note: If your OB/GYN care provider is unable to diagnose or treat your obstetrical/gynecological condition, you must receive a referral from your primary care provider before you seek additional care. If you receive obstetrical/gynecological care from a provider other than your OB/GYN care provider or primary care provider without a referral from your primary care provider, you will not receive benefits. See *Receiving Referrals From Your Primary Care Provider* later in this IMPORTANT INFORMATION section.

Changing Your Primary Care Provider and OB/GYN Care Provider. If you decide to switch to a different primary care provider or OB/GYN care provider, you can make your change in writing by submitting the change form available from customer service or you can make your change over the phone by calling the Wellmark Health Plan of Iowa, Inc., customer service center. Changes will be effective on the first day of the month following receipt of your request.

What To Do When Your Primary Care Provider Is Not Available. In the event your primary care provider is not available, he or she will designate a *backup provider* to act as a substitute. The backup provider will perform the same functions as your primary care provider. You will only ***go*** to a backup provider when your primary care provider or his or her office staff directs you to. When you receive care from or coordinated by the backup provider, you will receive benefits.

Supporting or Ancillary Services. There may be other providers who provide supporting or ancillary services to you under the direction of your primary care provider. These providers are referred to as *supporting service providers.* Some examples of supporting service providers include: ambulance service providers; anesthesiologists; assistant surgeons; home infusion therapy suppliers; home/durable medical equipment suppliers; independent laboratories; pathologists; physical therapists; and radiologists. Your primary care provider will refer you to a Unity Choice Network supporting service provider whenever possible. However, when you need an organ transplant (other than kidney) and transplant services are not available at a Unity Choice Network facility, your primary care provider will refer you to an appropriate transplant facility. This is one of the few circumstances when your primary care provider will refer you outside the Unity Choice Network.

Receiving Referrals From Your Primary Care Provider. If your primary care provider is unable to diagnose or treat your condition, he or she will refer you to a Unity Choice Network specialist. In order for you to receive benefits, referrals must be made by your primary care provider *before* you receive services. If the referral practitioner determines that additional treatment/visits are required beyond the scope of the original referral, he or she must consult with your primary care provider before proceeding. See *Referrals* in SECTION 3: NOTIFICATION REQUIREMENTS.

GETTING THE MOST OUT OF YOUR COVERAGE

To receive benefits under this policy, follow the simple guidelines explained below.

■ EMERGENCY OR ACCIDENTAL INJURY

When you need treatment for an emergency or accidental injury, you should try to contact your primary care provider first for direction and guidance. If this is not possible, Unity Choice provides the following options:

- You may go to the nearest hospital emergency room. For a definition of *emergency,* see the GLOSSARY at the end of this policy.

If you cannot get to the emergency room, dial 911 or your local emergency phone number for assistance.

Please note: If you receive emergency care for covered services and cannot reasonably reach a Unity Choice Network provider, emergency care received will be reimbursed as though the services were received from a Unity Choice Network provider.

NONEMERGENCY CONDITIONS

Generally, if you do not receive treatment for nonemergency health conditions from or coordinated by your primary care provider, you will not receive benefits. However, under the following circumstances you do not need to contact your primary care provider:

Gynecological and Maternity Care. If you select an OB/GYN care provider from the Unity Choice Network you may receive gynecological and maternity care from your selected OB/GYN care provider without contacting your primary care provider. For circumstances in which you may need to contact your primary care provider, see *Choosing Your Obstetrical/Gynecological (OB/GYN) Care Provider* earlier in this IMPORTANT INFORMATION section.

Mental Health Conditions and Chemical Dependency. When you need treatment for mental health conditions or chemical dependency (MHCD), ***call the Wellmark Health Plan of Iowa, Inc., Mental Health and Chemical Dependency Case Manager*** at the telephone number listed on the back of your Wellmark Health Plan of Iowa, Inc., identification card. You do not need to contact your primary care provider. If you receive MHCD services without first consulting with the case manager, *you will not receive benefits.*

Chiropractic Care. When you need chiropractic care, you may receive care from any Unity Choice Network chiropractor for your first five visits per benefit period without contacting your primary care provider. If you receive care beyond your first five visits without a referral from your primary care provider, *you will not receive benefits.*

Vision Exams. When you need an annual vision exam, you may receive the exam from any Unity Choice Network ophthalmologist or optometrist. You do not need to contact your primary care provider. Other covered services from an ophthalmologist or optometrist require a referral from your primary care provider. If you receive covered services, other than an annual vision exam, from an ophthalmologist or optometrist without a referral from your primary care provider, *you will not receive benefits.*

OUT-OF-AREA COVERAGE

You are eligible for benefits for services received out-of-area from providers who are not in the Unity Choice Network (including out-of-country providers) *only* in the following situations: *emergencies; accidental injuries; referrals under special circumstances; and urgent care* ***and*** *Guest Membership Services as described later.* Check the GLOSSARY at the back of this policy for definitions of *emergency* and *accidental injury.*

Guest Membership. If you are traveling long-term you are eligible to become a guest member at **an** affiliated HMO any time you are out of the Unity Choice Network service area for at least 90 days. To set up a guest membership, follow the guidelines listed below:

- Before you or a covered family member leave the Unity Choice service area, contact your Unity Choice Guest Membership coordinator by calling 1-515-235-4200 or by calling the customer service number on your Unity Choice identification card.
- The Guest Membership coordinator will send you an application and establish a guest membership for you at the HMO where you or your covered family member will be temporarily residing.
- You will select a primary care provider from the host network **and** receive services and benefits from the host HMO.

Using the BlueCard Program for Emergency Care. As a member of Wellmark Health Plan of Iowa, Inc., you are eligible to use the BlueCard program in cases of emergency or accidental injury.

Unity Choice is a product of Wellmark Health Plan of Iowa, Inc., an affiliate of Wellmark Blue Cross and Blue Shield of Iowa, independent licensees of the Blue Cross and Blue Shield Association. We participate with other Blue Cross and Blue Shield Plans in a national program called the BlueCard Program. This program ensures that members of any Blue Plan have access to the advantages of participating providers throughout the United States.

Always carry your Wellmark Health Plan of Iowa, Inc., identification card—also called the ***Bluecard.*** You should present the card to your provider at the time you receive care. Your BlueCard is important should you require medical services for an emergency or accidental injury in a state other than Iowa. Your BlueCard tells participating providers which independent Blue Cross and/or Blue Shield Plan is yours. It also ensures that you receive all the conveniences you're accustomed to when you receive medical services at home in Iowa.

In an emergency situation, seek care at the nearest hospital emergency room. Whenever possible, before receiving services, you should always ask the out-of-state provider if he or she participates with the Blue Cross and/or Blue Shield Plan in that state. By confirming that the provider participates, not only will you have access to the advantages explained below, but also you will know that the provider is licensed and recognized in that state.

When you receive covered services from participating providers in other states all **of** the following statements are true:

- Claims are filed for you.
- These providers agree to accept payment arrangements of the Blue Cross and/ or Blue Shield Plan in that state, which may result in savings.
- The settlement amount is sent directly to these providers.

Please note: When you receive covered services from participating providers in other states, you are responsible for notification requirements. See SECTION **3:** NOTIFICATION REQUIREMENTS.

UNDERSTANDING THIS POLICY

WHAT YOU SHOULD KNOW ABOUT THIS POLICY

It's important that you understand all parts of this **Unity** Choice policy in order to get the most out of your coverage. To help make the information easier to understand, we use the words ***you and your to refer to you, the policyholder. We, us,*** and ***our*** refer to Wellmark Health Plan of Iowa, Inc.

HOW THIS POLICY IS ORGANIZED

This policy outlines the benefits available to you under the group health program. It is divided into these main sections:

- **Benefits**
- **Services Not Covered**
- **Notification Requirements**
- **Your Payment Obligations**
- **Filing Claims**
- **Your Policy**
- **Glossary**

You should understand that information in one section may be related to other sections. To help you find crucial information, we direct you

within the text to appropriate sections whenever possible.

QUESTIONS WE ASK WHEN YOU RECEIVE HEALTH CARE

Even though a service may appear in SECTION 1: BENEFITS, you should know that before you are eligible to receive benefits, we first answer all of the following questions:

Is The Service Medically Necessary? All services must be medically necessary. We decide what is medically necessary and our decision is final and conclusive. Medically necessary means those covered services that are determined to be:

- *Appropriate and necessary* for the symptoms, diagnosis, or treatment of your condition.
- *Providedfor the diagnosis* or direct care and treatment of the condition and enabling you to make reasonable progress in treatment.
- *Within standards of professional practice* and given at the appropriate time and in the appropriate setting.
- *Not primarily for your convenience* or the convenience of your physician or other provider.
- *The most appropriate level of covered services* which can safely be provided.

Did You Receive Care From or Coordinated By Your Primary Care Provider? Generally, to receive benefits, you must receive care from or coordinated by your primary care provider. For circumstances in which you **do** *not* need to contact your primary care provider, see *Getting the Most Out of Your Coverage* earlier in this IMPORTANT INFORMATION section.

Is the Service Subject to Contract Limitations? Contract limitations refer to amounts that are your liability based on your contractual obligations with us. Examples of contract limitations include all of the following:

- Amounts for services that are not medically necessary. See Is *the Service Medically Necessary?* earlier in this section. You are responsible for these amounts only if you receive services from:
  --A non-Unity Choice Network provider; or
  --A Unity Choice Network provider with whom you sign a statement accepting financial responsibility for any services that we determine are not medically necessary. If you do not sign such a statement, the Unity Choice Network provider is responsible for these amounts.
- Amounts for services that are not covered under this policy. See SECTION 2: SERVICES NOT COVERED.
- Amounts for services that have reached contract maximums. See the SUMMARY OF PAYMENT at the beginning of this policy.
- Any difference between the billed charge and maximum allowable fee. ***Please note:*** This only applies if you receive services from a provider who is not in the Unity Choice Network and who does not participate with Wellmark Blue Cross and Blue Shield of Iowa. See SECTION 4: YOUR PAYMENT OBLIGATIONS.
- Penalty amounts for failure to follow notification requirements properly. See SECTION 3: YOUR NOTIFICATION REQUIREMENTS.

WHAT YOU CAN DO TO HELP CONTROL HEALTH CARE COSTS

You have the ability to help control health care costs by being a wise health care consumer. Make informed decisions about your health care. Be an active participant in your treatment. Talk with your provider and ask questions. Understand the treatment program and any risks or complications associated with it.

The following are additional tips you will want to follow to help control costs:

Practice Good Health Habits. Staying healthy is the best way to control your medical costs. Take care of yourself all year long. Eat a balanced diet. Exercise regularly. Get enough sleep. Learn ways to handle stress. Don't use alcohol. Don't smoke.

See Your Primary Care Provider Early. Don't let a minor health problem become a major one. Doing so will make treatment for your condition more difficult and expensive.

Receive Routine Check-ups. Receive routine physical examinations from your primary care provider and selected OB/GYN care provider who know you and are familiar with your medical history. Doing so will provide you with better information about your overall health.

Review Your Medical Bills Carefully. Take time to read and understand your Explanation of Health Care Benefits statement. This statement explains how we applied your coverage to the claim submitted to us. You will receive this statement in the mail. Make sure you are billed only for those services you receive. If you have any questions after reading your Explanation of Health Care Benefits statement, please call **1-800-892-2397.**

■ INTERPRETING THIS POLICY

We will interpret the provisions of this policy and determine the answer to all questions that arise under it. If any benefit in this policy is subject to a determination of medical necessity, we will make that factual determination. Our interpretations and determinations are final and conclusive.

There are certain rules you must follow in order for us to properly administer your benefits. Different rules appear in different sections of your policy. We urge you to become familiar with the entire policy.

■ HELPING YOU WHEN YOU HAVE QUESTIONS

If you have any questions after you read this policy, please call **1-800-892-2397.**

Your Unity Choice policy covers many services which are called benefits. Benefits are generally available only when you receive care from or coordinated by your primary care provider (see the IMPORTANT INFORMATION section). All covered services must be medically necessary. All covered services are subject to contract limitations.

Please note: Some services may be subject to contract maximums. See Service Limitations, *Benefit* Period Maximum, and *Lifetime* Benefits Maximum on the SUMMARY OF PAYMENT at the beginning of this policy.

This section is divided into the following categories:

- Facilities and Their Services
- Practitioners and Their Services
- Other Provider Services
- Special Programs
- Limited Services

FACILITIES AND THEIR SERVICES

■ APPROVED FACILITIES

Before we approve a facility for contracting or payment purposes, it must meet certain licensing, certification and/or accreditation standards. The following is a list of general types of facilities we recognize:

Ambulatory Surgical Facility provides surgical services on an outpatient basis.

Community Mental Health Center provides outpatient treatment for mental health conditions.

Facility for Treatment of Chemical Dependency provides treatment for chemical dependency conditions.

Hospital means a facility that provides for the diagnosis, treatment, or care of injured or sick persons. The facility must be licensed as a hospital under applicable law.

Nursing Facility provides continuous skilled nursing services as ordered and certified by your attending physician. A registered nurse (R.N.) must supervise services and supplies on a 24-hour basis. The facility must be licensed as a nursing facility under applicable law.

■ APPROVED FACILITY SERVICES

The following list describes approved facility services which are covered on an inpatient and outpatient basis when billed by an approved facility, unless specifically stated otherwise:

Accidental Injury Services.

Anesthetics and their Administration — but not local *or* topical anesthesia that is billed separately *from* related surgical *or* medical procedures.

Blood.

Blood Administration.

Chemotherapy Services for treatment of a malignancy.

Corneal Grafts.

Dietary Services — but only as an inpatient.

Dressings and Casts such as gauze, cotton, and fabric plaster.

Drugs and Biologicals. The drugs and biologicals must be approved by the Food and Drug Administration. This category includes such supplies as globulin, serum, vaccine, antitoxin, or antigen used in the prevention or treatment of disease.

Emergency Care.

General Nursing Care — but *only* as an inpatient.

Hemodialysis Services when provided to you as an inpatient of a hospital or as an outpatient in a Medicare-approved dialysis center.

Inhalation Therapy.

Intravenous Injections and Solutions.

Meals — but only as an inpatient.

Medical and Surgical Supplies.

Occupational Therapy—but only for services to treat the upper extremities, which means the arms *from* the fingers to the shoulders. ***You*** are *not* covered for occupational therapy supplies.
Physical Therapy.
Rooms.
Special Care Units including burn care units, cardiac care units, delivery rooms, intensive care units, isolation rooms, operating rooms, and recovery rooms.
Speech Therapy—*but only* to restore speech lost due to illness or injury. You must receive prior approval *before* receiving speech therapy. ***Please note:*** Your primary care provider will request prior approval for you. See Prior Approval in SECTION 3: NOTIFICATION REQUIREMENTS.

PRACTITIONERS AND THEIR SERVICES

■ APPROVED PRACTITIONERS

We cover services you receive from most practitioners who are recognized by us and who meet certain licensing, accreditation, and certification standards. The following are some of the practitioners we recognize:
Advanced Registered Nurse Practitioners.
Chiropractors.
Doctors of Osteopathy.
Health Service Providers in Psychology. From this point on in the policy, these providers will be referred to as psychologists. ***Please note:*** You must call the Wellmark Health Plan of Iowa, Inc., Mental Health and Chemical Dependency Case Manager for precertification before you receive services from a psychologist. See *Precertification* in SECTION 3: NOTIFICATION REQUIREMENTS.
Licensed Independent Social Workers.
Medical Doctors.
Occupational Therapists—but only for services to treat the upper extremities, which *means* the arms *from* the *fingers* to the *shoulders.*
Ophthalmologists.
Optometrists.
Oral Surgeons.
Physical Therapists.
Physician Assistants.
Podiatrists.

■ APPROVED PRACTITIONER SERVICES

The following list describes services we cover when received from an approved practitioner:
Accidental Injury Services.
Anesthetics and their Administration—but *not* the administration of local or topical anesthesia.
Assisting Surgeon Services.
Chemotherapy Services for treatment of a malignancy.
Corneal Grafts.
Dental Services. Most dental services are generally covered under Blue Dental, your dental program (and not under this health coverage). However, there are exceptions when services are covered under this policy and are limited to the following list:

- Correction of Bone Abnormalities of the jaw that are demonstrable at birth.
- Correction of a Lesion (an abnormal change in the mouth due to injury or disease).
- Dental Treatment of Accidental Injuries. Treatment must be completed within three months of the date of the injury. Injuries associated with or resulting from the act of chewing are never covered.
- Incisions of accessory sinus, mouth, salivary glands or ducts.
- Manipulation of a jaw dislocation.
- Reduction of Facial Bone Fractures.
- Surgical Removal of Impacted Teeth as an inpatient or outpatient of a facility only when you have a medical condition (such as hemophilia) that requires hospitalization for their removal.

Emergency Care.
Hemodialysis Services when provided to you as an inpatient of a hospital or as an outpatient in a Medicare approved dialysis center.
Maternity Services including pre- and postnatal care, complications, and delivery. Inpatient coverage will be provided for a

minimum of 48 hours for normal labor and delivery, or 96 hours for delivery by cesarean section. In the event you are discharged from the hospital within these time frames, you are covered for one postpartum home visit by a registered nurse (R.N.). This nurse must be from a home health agency under contract with us or employed by the practitioner giving you obstetrical care. ***Please note:*** If you become pregnant, contact your local Department of Human Services office immediately. They will need to determine your eligibility for Medicaid.

Medical Services (other than surgical or obstetrical) provided by your practitioner while you are an inpatient or an outpatient.

Musculoskeletal Treatment.

Occupational Therapy—but *only for services to treat the upper extremities, which means the arms from the fingers to the shoulders. You are not covered for occupational therapy supplies.*

Physical Therapy.

Preventive Care. You have coverage for preventive care according to the *Preventive Care Guidelines for Adults and Children* found in your *Preventive Care Booklet.* You also have coverage for:

Vision Examinations (Annual Vision Exams).

Radiation Therapy.

Second Opinions as referred by your primary care provider.

Surgical Services which include operative and cutting procedures, major endoscopic procedures, and preoperative and postoperative care.

X-Ray and Laboratory Services are covered for the diagnosis and treatment of an illness or injury or when related to a routine physical exam. Some examples of covered tests are:

Allergy Testing.
Computerized Tomography Scan (CT Scan).
Electroencephalograms (EEG).
Electrocardiograms (EKG **or ECG).**
Holter Monitoring.
Mammography X-Ray.
Pap Smears.
Pathology Tests.
Stress Tests.
Ultrasound.

If you have a question about a specific test, please call us.

OTHER PROVIDER SERVICES

■ APPROVED SERVICES

Your benefits also include the following services:

Ambulance Services (professional air or ground) to the nearest adequate hospital or nursing facility to treat your illness or injury. Local air and ground ambulance means that you are transported to a hospital or nursing facility in the surrounding area where your ambulance transportation began. To determine if we will cover your ambulance transportation, we consider all of the following:

- No other method of transportation is appropriate.
- The services necessary to treat this illness or injury are not available in the hospital or nursing facility where you may be an inpatient.
- The hospital or nursing facility is the nearest one with adequate facilities to treat your medical condition.
- The facility is in the Unity Choice Network and is accessible by your primary care provider, when appropriate. ***Please note:*** In an emergency situation, you may seek care at the nearest appropriate facility.

Hearing Aids.

Hearing Exams when they are part of the routine physical examination.

Home Infusion Therapy including the administration of nutrients, antibiotics, and other drugs and fluids intravenously.

Home/Durable Medical Equipment including durable medical equipment items such as wheelchairs and hospital beds, which are either purchased or rented. Benefits for rental items will never total more than the purchase price.

You must have a referral from your primary care provider for all purchased or rented home medical equipment. In addition, your primary care provider should request prior approval for all rental items and any purchased items over **$250.** See SECTION 3: NOTIFICATION REQUIREMENTS.

Oxygen and Equipment needed to administer oxygen.

Prescription Drugs and Medicines. Most prescription drugs and medicines that bear the legend, "Caution, Federal Law prohibits dispensing without a prescription," are generally covered under *Blue Rx,* your managed drug program, and not under this health coverage. (For more information about your managed drug program, refer to your Blue Rx managed drug program benefits policy.) However, there are exceptions when prescription drugs and medicines are covered under this policy. Some examples include:

- growth hormones (with prior approval). ***Please note:*** Your primary care provider will request prior approval for you.
- self-administered injectables (not including insulin, Imitrex, or EpiPen, which are covered under Blue Rx, your managed drug program).

Private Duty Nursing services usually last for extended periods of time and are covered when:

- Services are provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) in your home; and
- Services are prescribed by a practitioner for the treatment of illness or injury; and
- You are homebound or, if you are not homebound, services are *not more* costly *than* alternative services that would be effective for diagnosis and treatment of your condition and, in the judgment of Wellmark Health Plan of Iowa, Inc., which shall be conclusive, cannot reasonably be provided in an alternative setting.

Your primary care provider must receive precertification *before* you receive private duty nursing. See SECTION 3: NOTIFICATION REQUIREMENTS.

Prosthetic Appliances used to replace a missing, natural part of the body and braces used to support or restrict movement of weakened or deformed body parts. This benefit does not include dental braces. Your primary care provider must receive prior approval *before* you purchase prosthetic appliances over **$250.** See SECTION 3: NOTIFICATION REQUIREMENTS.

SPECIAL PROGRAMS

BETTER BEGINNINGS'

Better Beginnings is a preconception and prenatal case management program for women who are planning a pregnancy or who are expecting a baby. It focuses on healthy pregnancies and healthy babies by identifying expectant mothers who are at high risk for pregnancy complications or premature delivery. Participation is voluntary. **As** soon as you are pregnant, and you have been deemed ineligible for Medicaid, you should call the Better Beginnings nurse to enroll. The phone number is **1-800-Baby-to-B** (**1-800-222-9862).** You do not need to contact your primary care provider.

DIABETES EDUCATION (OUTPATIENT)

An outpatient diabetes education program helps a type I or type II diabetic and his or her family understand the diabetes disease process and the daily management of diabetes. **You** must receive diabetes education from a state-approved outpatient education program. This service **is** limited by a contract maximum. See the SUMMARY OF PAYMENT at the beginning of this policy.

HOME HEALTH SERVICES

Home health services are covered when all of the following statements are true:

- You require a medically necessary skilled service such as skilled nursing, physical therapy, or speech therapy.
- Services are received from an agency accredited by the Joint Commission for the

Accreditation of Health Care Organizations (JCAHO) and/or a Medicare certified agency.

- Services are referred by your primary care provider and approved by a Wellmark Health Plan of Iowa, Inc., case manager for the treatment of illness or injury. ***Please note:*** Your primary care provider will request approval for you.
- Services are not more costly than alternative services that would be effective for diagnosis and treatment of your condition.

Some covered services and supplies include:

Home Health Aide Services—when *provided in conjunction with a medically necessary skilled service also received in the home.*

Inhalation Therapy.

Medical Equipment.

Medical Social Services.

Medical Supplies.

Occupational Therapy—but *only for services to treat the upper extremities, which means the arms from the fingers to the shoulders. You are not covered for occupational therapy supplies.*

Oxygen and Equipment for its administration.

Parenteral and Enteral Nutrition.

Physical Therapy.

Prescription Drugs and Medicines administered in the vein or muscle.

Prosthetic Appliances and Braces.

Skilled Nursing Visits—but *treatment cannot last more than two hours per visit* and must be given by a registered nurse from an agency accredited by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) and/or a Medicare-certified agency.

Speech Therapy—but *only to restore speech lost due to illness or injury.*

HOSPICE SERVICES

A hospice program provides care (generally in a home setting) for patients who are terminally ill and who have a life expectancy of six months or fewer. Hospice care covers the same services as described under home health services, as well as hospice respite care from a facility approved by Medicare or by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO). ***Please note:*** Your primary care provider will request precertification approval for you.

Hospice Respite Care offers rest and relief help for the family caring for a terminally ill patient. Inpatient hospice respite care can take place in a nursing home, nursing facility, or hospital. Hospice respite care must be used in increments of not more than five days at a time. Your benefits ***do not*** include bereavement counseling and services of volunteers or clergy. This service is limited by a contract maximum. See the **SUMMARY OF PAYMENT** at the beginning of this policy.

INDIVIDUAL CASE MANAGEMENT (ICM)

Certain medical conditions may require costly, long-term care. A hospital may not be the most appropriate setting for your treatment. That's why Unity Choice provides you with the opportunity to receive alternative benefits to help meet health care needs resulting from extreme illness or injury (providing that costs do not exceed inpatient facility costs). You, your primary care provider, and the hospital can work with our case managers to identify and arrange alternative treatment plans to meet your special needs and to assist in preserving your health care benefits. We call this benefit *individual case management* (ICM). Conditions and treatment planning where ICM might be appropriate are:

Coma.

HIV/AIDS.

Long-term Intravenous Therapy.

Respirator Dependency.

Spinal Cord Injury.

Traumatic Brain Injury.

Some services are excluded or listed as standard policy limitations. However, we may waive certain exclusions or limitations for individual case management with the agreement of our

medical director and your primary care provider. Each 'individualcase management case is handled on an individual basis and the benefit program is tailored to address the circumstances of each case.

■ NUTRITION EDUCATION

Nutrition education helps improve your understanding of your metabolic nutritional condition and provides education for managing your nutritional requirements. Nutrition education is appropriate for, but not limited to:

Glucose Intolerance.
High Blood Pressure.
Lactose Intolerance.
Morbid Obesity.

■ VISION CARE

Vision care is limited to those services and supplies necessary to adequately correct an existing vision disorder. Benefits include:

- One comprehensive eye examination or visual survey every **12** months for each enrollee under **19** years of age.
- Two lenses every **12** months for each enrollee under **19** years of age.
- One frame every **12** months for each enrollee under **19** years of age.

You are limited to the following dollar amount for these services and supplies:

Comprehensive Eye Examination or Visual Survey $50.00
One Pair Frames/Lenses or Contact Lenses $100.00

Benefits do not include:

Replacement of lost, stolen or broken lenses, contact lenses or frames.
Orthoptics, Vision Training, Aniseikonic Studies and prescriptions, reading problem studies or other procedures determined to be special or unusual.

LIMITED SERVICES

■ COSMETIC SURGERY

Cosmetic surgery is limited to corrective surgery that has the primary purpose of restoring function after an illness or accidental injury, or is the result of a birth or physical defect. If the reason for surgery meets the criterion of restoring function, and your primary care provider receives *written prior approval,* then you are eligible to receive benefits even if there is **an** incidental improvement in physical appearance. See *Prior Approval* in SECTION **3:** NOTIFICATION REQUIREMENTS.

Cosmetic surgery intended to improve your appearance when it is unrelated to an injury, illness, physical or birth defect, ***is not*** covered. Complications of a noncovered cosmetic surgery are also ***not*** *covered.* See *Miscellaneous* and *Therapy, Self-Motivation, and Other Programs* in SECTION **2:** SERVICES NOT COVERED.

■ MENTAL HEALTH CONDITIONS AND CHEMICAL DEPENDENCY (MHCD) TREATMENT

To receive benefits for treatment of mental health conditions and chemical dependency, you must first call **1-800-777-4295** to authorize treatment through the Wellmark Health Plan of Iowa, Inc., Mental Health and Chemical Dependency Case Manager. You do not need a referral from your primary care provider. If you do not precertify services *before* treatment, *you will not receive benefits.* See *Precertification* in SECTION 3: NOTIFICATION REQUIREMENTS.

■ MORBID OBESITY SURGERY

Before you receive services for morbid obesity surgery, your primary care provider should request prior approval. See *Prior Approval* in SECTION 3: NOTIFICATION REQUIREMENTS. You must meet all of the following requirements to receive benefits:

- Your weight is more than twice the ideal weight of a medium-frame person based on standard charts used by the life insurance industry.

- You have been considered morbidly obese by a physician for at least five years.
- Non-surgical methods of weight loss have been supervised by a physician for at least three years without success.

TRANSPLANTS

You have coverage for transplants of the heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/ kidney, small bowel, and liver. You also have coverage for certain autologous and allogeneic bone marrow/stem cell transfer transplants as described later.
You do not have coverage for any of the following:

- artificial (mechanical) organs.
- non-human organs.

Please note: Charges related to the donation of an organ are usually covered by the recipient's health coverage. However, if donor charges are not covered by the recipient's coverage, and you are a donor, the charges will be covered by this policy.

Transplants are limited in the following ways:

- Your primary care provider should follow written prior approval requirements for all transplants (except kidney). See SECTION 3: NOTIFICATION REQUIREMENTS.
- We must recognize the facility as a Unity Choice Network facility for all transplants (except kidney) to be eligible for benefits. If transplant services are not available at a Unity Choice Network facility, we must recognize the facility as Blue Quality Centers for Transplant.
- Transplants are limited by contract maximums. See the SUMMARY OF PAYMENT at the beginning of this policy.

Autologous Bone Marrow Transplants.

Benefits for autologous bone marrow transplants, which include autologous hematopoietic stem cell transplants, autologous peripheral blood stem cell transplants, and syngeneic marrow/stem cell transplants, ***are limited to*** treatment of the following conditions:

- Non-Hodgkin's lymphoma, including
  - **Low** grade lymphoma after recurrence following first-line therapy or in first remission with biologically aggressive disease; or
  - Intermediate grade lymphoma after failing first-line chemotherapy, or in first complete remission with poor prognostic factors suggesting less than a 30 percent chance of durable first complete remission; and with disease that remains sensitive to standard-dose chemotherapy; or
  - High grade lymphoma sensitive to standard-dose chemotherapy with poor prognosis.
- Hodgkin's lymphoma recurrent after standard chemotherapy, showing response to standard chemotherapy or in early relapse.
- Neuroblastoma, Stage III or IV when further treatment with a conventional-dose therapy is not as likely to achieve a durable remission for the patient.
- Breast and ovarian cancers that involve either:
  - Advanced disease shown to be responsive to standard-dose chemotherapy; or
  - Limited disease with less than a **30** percent chance of durable complete remission with standard therapy.
- Germ cell tumors after first relapse, with chemosensitive disease.
- Ewing's sarcoma and soft tissue sarcoma shown to be chemosensitive and with less than **30** percent chance of durable complete remission with standard chemotherapy.
- Acute lymphocytic and non-lymphocytic leukemia following a first or subsequent remission when:
  - you are at high risk for relapse; and
  - HLA compatible donors are not available for allogeneic bone marrow support; and

— the expected outcome of autologous transplant is approximately equivalent to allogeneic transplant.

- Multiple myeloma after first complete remission or where disease can be shown to be chemosensitive to standard chemotherapy and where allogeneic transplant is not a viable option.

You ***are not covered*** for autologous bone marrow transplants, including autologous hematopoietic stem cell transplantation, autologous peripheral blood stem cell transplantation, and syngeneic marrow/stem cell transplants, for the treatment of the following:

- Any condition not listed previously.
- Chemotherapy-resistant breast cancer.
- Chemotherapy-resistant leukemias.
- Testicular malignancies that are not responding (as opposed to partial responders) to treatment and have failed second or third line regimens.
- Metastatic colon cancer.
- Malignant melanoma.
- Any malignancies for which the transplant is clearly a palliative form of treatment.
- Any malignancy for which there are less than two published papers in peer-reviewed medical journals attesting to some success with this method of treatment.
- High grade intrinsic tumor of the brain, e.g., glioblastoma multiforme; anaplastic astrocytoma.

Allogeneic Bone Marrow Transplants. Benefits for allogeneic bone marrow transplantation, which include high-dose chemotherapy with allogeneic hematopoietic stem cell support, ***are limited tu*** treatment of the following conditions:

- Severe aplastic anemia including Fanconi's anemia.
- Myelodysplastic syndrome (chronic myelomonocytic leukemia, refractory anemia with excess blasts or refractory anemia with excess blasts in transformation).
- Homozygous Beta-Thalassemia (thalassemia major).
- Wiskott-Aldrich Syndrome.
- Severe combined immunodeficiencies.
- Infantile Malignant Osteopetrosis (Albers-Schonberg syndrome or marble bone disease).
- Mucopolysaccharidoses (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants).
- Mucolipidoses (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy).
- Lympho-hematopoietic malignancies including acute leukemia (undifferentiated, lymphoblastic or myeloblastic) at high risk for relapse; chronic myelocytic leukemia in chronic or accelerated phase; chronic lymphocytic leukemia; multiple myeloma; Hodgkin's or non-Hodgkin's lymphoma not curable with standard therapy or with autologous bone marrow transplantation. Benefits for allogeneic bone marrow transplantation in these categories require that you also satisfy both of the following additional criteria:
  - — Your disease characteristics and treatment history suggest that the probability of achieving a durable complete remission is greater with high-dose chemotherapy compared to standard-dose chemotherapy; and
  - — You do not have a concurrent condition that would seriously jeopardize the achievement of a durable complete remission with high-dose chemotherapy with hematopoietic stem cell support.

You ***are not coveredfur*** allogeneic bone marrow transplantation or high-dose chemotherapy with allogeneic hematopoietic stem cell support for the treatment of

- Any condition not listed previously.
- Primary intrinsic tumors of the brain.
- Polycythemia vera.

Your policy ***does*** not provide benefits for certain procedures, services, or supplies that are listed in this SERVICES NOT COVERED section. For your convenience, we divided this section with category headings. Don't mistake these category headings for exclusions—they are meant only to help you find the information you are looking for. Actual exclusions are listed beneath the category headings.

Please note: Even if the service or supply is not specifically listed as an exclusion, it may not be covered under this policy. Call us if you are unsure if a specific service or supply is covered.

MENTAL HEALTH AND CHEMICAL DEPENDENCY TREATMENT

Bereavement Counseling or Services. You are not covered for bereavement counseling or services of volunteers or clergy.

Family Counseling. You are not covered for family counseling or other training services.

Treatment for Certain Mental Health Conditions. You are not covered for treatment for certain mental health conditions, including the following:

Certain Developmental and Learning Disorders.

Certain Disorders of Early Childhood, such as academic underachievement disorder.

Communication Disorders, such as stuttering **and** stammering.

Impulse Control Disorders, such as pathological gambling.

Nicotine Dependence.

Sensitivity, Shyness, and Social Withdrawal Disorder.

Sexual Identification or Gender Disorders. You are also not covered for sex change surgery.

FERTILITY AND INFERTILITY

Abortion. You are not covered for services or supplies related to a voluntary abortion unless:

- you suffer from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place you in danger of death unless an abortion is performed; or
- the pregnancy was the result of an act of rape or incest.

Contraceptives (Oral). You are not covered for *oral* contraceptives under this policy. However, you are covered for oral contraceptives under your Blue Rx drug coverage and contraceptive devices and implanted or injected contraceptives under this health policy.

Donor Semen and Oocytes. You are not covered for the collection or purchase of donor semen (sperm) or oocytes (eggs); the services of a surrogate parent; or the freezing of sperm, oocytes, or embryos.

Infertility Treatment. You are not covered for the diagnosis or treatment of male or female infertility.

Sterilization Reversal. You are not covered for the reversal of a vasectomy or tubal ligation.

MISCELLANEOUS

Anesthesia that is Local or Topical. You are not covered for local or topical anesthesia when billed separately from related surgical or medical procedures.

Arch Supports. You are not covered for orthotic foot devices such as arch supports or in-shoe supports, orthopedic shoes, elastic supports, or

exams to prescribe or fit such foot devices, supports, or shoes.

Complications of a Noncovered Procedure. You are not covered for complications of a noncovered procedure.

Dental Care. You are not covered for dental care except those services listed in SECTION 1: BENEFITS under ***Approved Practitioner Services.***

Drugs. You are not covered under this policy for prescription or nonprescription drugs and medicines except as stated in SECTION 1: BENEFITS.

Effective Date. You are not covered for services or supplies that you receive before the effective date of coverage under this policy.

Elastic Stockings and Bandages. You are not covered for elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.

Genetic Testing and Counseling. You are not covered for molecular genetic testing (specific gene identification) or related genetic counseling.

Hearing Exams. You are not covered for hearing exams except as stated in SECTION 1: BENEFITS.

Investigational Treatment. You are not covered for services or supplies that are considered investigational or experimental. Treatment is considered investigational or experimental when the service, procedure, drug, or treatment has progressed to limited human application, but has not achieved recognition as being proven and effective in clinical medicine. Such recognition may be achieved through

- final approval for use of a specific service, procedure, drug, or treatment for a specific diagnosis from the appropriate governmental regulatory body;
- scientific evidence permitting a consensus conclusion that recognizes the effectiveness of the specific service, procedure, drug, or treatment on health outcomes for a specific diagnosis.

We shall determine whether a service, procedure, drug, or treatment is investigational or experimental using these criteria.

Maxillary and Mandibular Implants. You are not covered for maxillary or mandibular implants (osseointegration).

Motor Vehicles. This policy does not cover the cost of purchase or rental of motor vehicles such as cars and vans. You are also not covered for equipment or costs associated with converting a motor vehicle to accommodate a disability.

Personal Convenience Items. You are not covered for personal convenience items that are useful in the absence of illness or injury, (including air conditioners, dehumidifiers, ramps, home remodeling, hot tubs, and swimming **pools).**

Temporomandibular Joint Disorder. You are not covered for services or supplies for treatment of temporomandibular joint disorder (TMD), myofascial pain syndrome, or craniomandibular joint dysfunction.

Travel or Lodging Costs. You are not covered for expenses to pay for the cost of travel or lodging.

Vision. You are not covered for orthoptics (eye-muscle exercises) or surgery to correct eye refractions, such as keratotomies. This exclusion does not apply to Vision Care as stated in SECTION 1: BENEFITS.

Wigs. You are not covered for wigs and artificial hair pieces.

PROVIDER TYPE

Provider is an Immediate Family Member. You are not covered for services or supplies when given to you by a provider who is within your immediate family (immediate family means a parent, child, or spouse).

Self Referral. You are not covered for services or supplies you receive from a provider without a referral from your primary care provider. This exclusion does not apply to:

- accidental injuries.

- annual vision exams received from a Unity Choice Network ophthalmologist or optometrist.
- chiropractic care from a Unity Choice Network chiropractor for the first five visits per benefit period.
- gynecological and maternity care received from or coordinated by your selected OB/GYN care provider.
- medical emergencies.
- treatment of mental health conditions or chemical dependency for which you have precertified with the Wellmark Health Plan of Iowa, Inc., MHCD case manager. See SECTION 3: NOTIFICATION REQUIREMENTS.

PREVENTIVE AND ROUTINE CARE

Routine Health Screenings. You are not covered for routine, periodic physical or health examinations or screening procedures which are performed solely for school, sports, employment, insurance, licensing, or travel.
Routine Foot Care. You are not covered for the services or supplies related to routine foot care.

COVERED BY OTHER PROGRAMS OR LAWS

Governmental Programs. You are not covered for services or supplies when you are entitled to claim benefits from governmental programs, except Indian Health Service.
Military Service. You are not covered for services or supplies required to treat an illness or injury received while you are on active status in the military service.
Payment Responsibility. You are not covered for services or supplies when someone else has the legal obligation to pay for your care and when in the absence of this policy, you would not be charged.
Workers' Compensation Reimbursement. You are not covered for services or supplies that are or could have been compensated under Workers' Compensation laws, including services or supplies applied toward satisfaction of any deductible under your employer's Workers' Compensation coverage.

THERAPY, SELF-MOTIVATION, AND OTHER PROGRAMS

Acupuncture. You are not covered for services or supplies related to acupuncture.
Certain Inpatient Therapy. You are not covered for services or supplies provided primarily for diagnostic evaluations, physical therapy, or occupational therapy as an inpatient.
Cosmetic Services or Supplies. You are not covered for cosmetic services or supplies that are primarily to improve your natural appearance.
Custodial or Sanitaria Care or Rest Cures. You are not covered for custodial care, sanitaria care, or rest cures.
Educational or Recreational Therapy. You are not covered for educational or recreational therapy and services or supplies that are nonmedical.
Massage Therapy. You are not covered for massage therapy.
Occupational Therapy Supplies. You are not covered for occupational therapy supplies.
Self-help or Self-cure Programs. You are not covered for self-help or self-cure programs. This includes prescription gum and patches used for the purpose of smoking cessation.
Therapy to Treat Temporomandibular Joint Disorders (TMD). You are not covered for physical therapy, manipulations, dental extractions, or orthodontic treatment for TMD.
Weight Reduction Programs. You are not covered for weight reduction programs or supplies (including dietary supplements, foods, equipment, laboratory testing, examinations, and prescription drugs), whether or not weight reduction is medically appropriate.

SECTION 2: SERVICES NOT COVERED

TRANSPLANTS

Expenses for the Purchase of any Organ. You are not covered for expenses related to the purchase of any organ.

Mechanical or Non-Human Organs. You are not covered for services or supplies related to mechanical or non-human organs associated with transplants.

Transplant Services or Supplies. You are not covered for transplants other than heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, small bowel, liver, or bone marrow/stem cell transfer as stated in **SECTION 1: BENEFITS.**

Transportation of a Living Donor. You are not covered for expenses of transporting a living donor.

The following section explains mandatory notification requirements. ***Precertification, admission review, referrals, continued stay review, prior approval*** are all important components of your health care coverage. These components are the checks and balances of your health care coverage.

- ***Precertification, admission review,*** and ***continued stay review*** are solely to determine whether mental health and chemical dependency services, inpatient admissions, home health, hospice, private duty nursing, or home infusion meet the medical necessity criteria of this policy. ***Please note:*** Even if an inpatient admission is certified as medically necessary, all other provisions of this policy, including ***prior approval,*** remain applicable to determine whether you are eligible for benefits.
- ***Prior approval*** determines whether a particular service is medically necessary and a benefit of your policy. ***Please note:*** Even if you receive prior approval for a service, inpatient admissions are still subject to precertification. Generally, if you receive services from or coordinated by your primary care provider, notification requirements are handled for you. However, notification requirements are your responsibility when you:
- require emergency treatment in a facility that is not in the Unity Choice Network.
- require treatment for mental health conditions and chemical deuendencv.

Please read the information in this section closely. If you do not follow notification requirements properly, benefits may be reduced or denied completely—and you may have to pay for services yourself.

This section will explain:

- **Precertification**
- **Admission Review**
- **Continued Stay Review**
- **Prior Approval**
- **Referrals**
- **Appeal Process**

PRECERTIFICATION

MENTAL HEALTH CONDITIONS AND CHEMICAL DEPENDENCY (MHCD) TREATMENT

To receive benefits for any treatment of mental health conditions and chemical dependency, you must first call the Wellmark Health Plan of Iowa, Inc., Mental Health and Chemical Dependency Case Manager. We call this the precertification process. The case manager will determine whether the proposed inpatient or outpatient services meet the medically necessary criteria of this policy. If the case manager determines that the proposed inpatient or outpatient services meet medical necessity criteria, the services will be *certified. **Please note:*** Even if the services are certified as medically necessary, all other provisions of this policy remain applicable to determine whether you are eligible for benefits. You do not have to contact your primary care provider.

If in an emergency situation an inpatient admission is made without certification of medical necessity from a case manager, you have a 48-hour grace period to call the case manager.

To precertify emergency or nonemergency mental health and chemical dependency treatment, you should call **1-800-777-4295.** Your call will be taken by a *case manager.* The case manager staff is made up of psychiatric nurses, social workers, and other practitioners trained in the mental health and chemical dependency review process. Case managers are available for emergencies 24 hours a day, seven days a week, including holidays.

The *case manager* will discuss your case with you and will then assist you in selecting a Unity Choice Network provider. After your first meeting with the provider, an assessment will be made on recommended treatment.

If you do not call a Mental Health and Chemical Dependency Case Manager to precertify the services, *you will not receive benefits.* However, if in an emergency situation treatment is given without authorization from a case manager, you have a 48-hour grace period to call the case manager.

If you choose to have requested services performed even though the case manager was unable to certify medical necessity of the services, you will be responsible for the charges. You may appeal the decision to deny the certification of medical necessity as explained later in this section (see *Appeal Process).*

■ INPATIENT ADMISSIONS, HOME HEALTH SERVICES, HOSPICE SERVICES, PRIVATE DUTY NURSING, AND HOME INFUSION THERAPY

Planned admissions to a hospital, nursing facility, or other facility require precertification. The purpose of this process is to determine whether the admission meets the medical necessity criteria of this policy. ***Please note:*** Your primary care provider will handle precertification for you.

A *planned* admission **is** one that:

- can be scheduled in *advance even f your admission is that day;* and
- *is not an emergency* and if delayed would not result in death or permanent damage to your health.

Home health services, hospice services, private duty nursing, and *home infusion therapy* also require precertification and a referral from your primary care physician.

You or your Unity Choice Network provider should call the phone number listed on your identification (ID) card. Once your call is received, your request will be answered within one business day.

Please note: If your inpatient admission is for mental health and chemical dependency treatment, you must precertify using a different phone number. See earlier in this section under *Mental Health and Chemical Dependency (MHCD) Treatment.*

If you choose to have the requested services performed even though the request for benefits is denied (because services do not meet the medical necessity criteria of this policy), you will be responsible for the charges. You may appeal this decision to deny the certification for admission as explained later in this section under *Appeal Process.*

ADMISSION REVIEW

■ EMERGENCY ADMISSIONS

You or someone acting on your behalf must call within the specified length of time for an *admission review* when you are admitted to a

hospital, nursing facility or other facility for an emergency or obstetrical admission. The phone number is listed on your identification (ID) card. We call this procedure *admission review.* The purpose of this process is to determine whether the admission meets the medical necessity criteria of this policy.

Please note: If you receive emergency services from or coordinated by a Unity Choice Network provider, he or she will handle admission review for you.

You must notify us:
- within 48 hours of or on the first working day following an emergency admission to a hospital, nursing facility, or other facility that is not in the Unity Choice Network.
- if your hospital stay is longer than 48 hours for a normal labor and delivery.
- if your hospital stay is longer than 96 hours for a cesarean section.

Without the required admission review:
- your benefits will be denied if the services are found to be not medically necessary or not covered by your policy; and
- you run the risk of staying in the hospital longer than medically necessary. If this happens, you are responsible for the room and board charges for all non-covered days.

CONTINUED STAY REVIEW

REVIEW OF YOUR CARE

Your care throughout your stay in the hospital, nursing facility, or other facility will be reviewed. Your care will also be reviewed when your provider recommends home health care, hospice services, private duty nursing services, or home infusion therapy. This review is called *continued stay review.* The purpose of this review is to determine if services meet the medical necessity criteria as described in the **IMPORTANT INFORMATION** section.

If it is determined that your current level of care is no longer medically necessary, you, your attending physician, and the facility or agency will be notified 24 hours before your benefits for these services end. *The decision to end your benefits may be appealed as explained later in this section* (see *Appeal Process).*

Please note: We will notify you of the date when coverage for these services ends. We will not pay for services after that date.

PRIOR APPROVAL

APPROVAL FOR CERTAIN SERVICES

Before you receive certain services, supplies, or procedures, your primary care provider should request our written approval. We call this procedure *prior approval.* Written prior approval is a special service we offer you. The program helps determine if a proposed treatment plan is medically necessary and a benefit of this policy. *Without prior approval for the services listed in this section, we cannot confirm whether the proposed treatment plan is a benefit of this policy.* Even if you receive prior approval for a service, inpatient admissions are still subject to *precertification. Please note:* Your primary care provider will request prior approval for you.

The most common services we suggest written prior approval for include:

Bone Growth Stimulator.

Cardiac Rehabilitation over 18 sessions.

Communication System (Touch Talker).

Cornea Surgery to improve vision (Keratoplasty).

Cosmetic Surgery including, but not limited to: scar revisions, reconstruction of the nose (rhinoplasty), port wine stain surgery, surgery on the eyelids (blepharoplasty), and breast surgery (including reconstruction, reduction, and gynecomastia).

Ear Implants and Electromagnetic Bone Conduction Devices for hearing loss.

Electrical Stimulation of the Spine (Dorsal Column Stimulator).
Electronic Limbs (myoelectric and other electronic prosthetic devices).
Growth Hormones—Please ***note:*** Growth hormones are not covered under any circumstances for males taller than ***5*** feet ***6*** inches and females taller than ***5*** feet 2 inches.
Home/Durable Medical Equipment (any purchases over **$250** and all rentals).
Insulin Infusion Pump.
Morbid Obesity Surgery including, but not limited to stomach surgery (gastroplasty), stomach stapling (gastric stapling), stomach bypass (gastric bypass), or surgery for the removal of fat from the belly wall (panniculectomy and abdominoplasty).
Motorized Wheelchair including chairs with three or four wheels.
Prosthetic Appliances (any purchases over **$250).**
Speech Therapy.
Surgery to Correct Funneled or Hollowed Chest (Pectus Excavatum Surgery).
Transplants:

- **Bone Marrow/Stem Cell Transfers**
- **Heart**
- **Heart and Lung**
- **Liver**
- **Lung**
- **Pancreas**
- **Simultaneous Pancreas/Kidney**
- **Small Bowel**

Uvulopalatopharyngoplasty to reduce sleep apnea.

When your primary care provider requests prior approval, Wellmark Health Plan of Iowa, Inc., will determine if the requested service is medically necessary and a benefit of this policy from the written information provided by your primary care provider.

After reviewing the form, we will notify you and your provider of the decision. We will mail our notice to the most current addresses we have on record for you and your provider.

- If your request is approved, you know your policy covers the specific services or procedures. **Please** ***note: An*** inpatient admission for the approved procedure will then require *precertification*.
- If benefits are denied, you will receive written notice in which Wellmark Health Plan of Iowa, Inc., will list the reason(s) for denial.

Certain factors may alter or impact whether you receive approval. These factors include medical necessity, the place you receive services, policy coverage and the date you receive services.

Policy Coverage. Approval is based on the policy in effect for the patient on the date the approval is signed. If your health care coverage changes for any reason, perhaps because of a new job or a new policy, then the approval may not be valid. If your coverage changes before the approved procedure is performed, Wellmark Health Plan of Iowa, Inc., will need to check the coverage again.

Date of Service. You must receive the approved service or procedure within six months of the approval date. If you do not receive the service or procedure within six months of the approval date, your primary care provider must complete another prior approval request.

Benefit Amount. Benefits for the approved service is limited to the amount provided in the policy in effect for the patient on the date services are provided.

Your policy requires precertification for inpatient care, ***so*** you must also meet those requirements before the approved service can be performed on an inpatient basis. See earlier in this section under *Inpatient Admissions, Home Health Services, Hospice Services, Private* ***Duty*** *Nursing,* and *Home Infusion Therapy.* Remember, if you do not precertify a facility stay or MHCD

when required, your benefits will be reduced or denied completely.

Place of Service. To receive benefits for transplants (not including kidney) they must be received in a Unity Choice Network facility. If transplant services are not available at a Unity Choice Network facility, services must be received at Blue Quality Centers for Transplant.

REFERRALS

PRIMARY CARE PROVIDER REFERRALS

When your primary care provider is unable to diagnose or treat your condition, he or she will refer you to a Unity Choice Network specialist when medically necessary. There are generally three types of referrals:

- The first type of referral occurs when your primary care provider refers you to a specialist to provide a second opinion on your health. In this case, you would probably see the specialist only once or twice.
- The second type of referral occurs when your primary care provider refers you to a specialist for a short period of time for treatment of a specific condition.
- The third type of referral occurs when your primary care provider refers you to a specialist to manage your specific health condition.

If you require care that is beyond the scope of services available from a Unity Choice Network provider, you will be referred to a provider outside the network who has expertise in diagnosing and treating your condition. Your Unity Choice Network provider will comply with all notification requirements for you. ***Please note:*** Your primary care physician will refer you to providers within the network first.

APPEAL PROCESS

MAKING A COMPLAINT

If your claim has been denied or if you do not agree with our decision to reduce benefits or if you have a complaint regarding a claim, provider, or a service provided by us, you may issue a complaint by calling our customer service department at **1-800-892-2397.** The customer service department will then research and resolve the complaint in a timely manner and notify you of the result, along with your right to appeal, if appropriate.

FILING A FIRST LEVEL APPEAL

If you are not satisfied with the resolution of a Complaint, you may contact the Wellmark Health Plan of Iowa, Inc., Customer Service Department by phone or submit a written appeal by completing an *Enrollee Complaint/Appeal Form,* which we will provide at your request. The Enrollee Complaint/Appeal Form must be filed within 120 calendar days of the complaint decision.

Enrollee Complaint/Appeal Forms should be sent to:

Wellmark Health Plan of Iowa, Inc.
Enrollee Appeal Committee
Station **52**
636 *Grand Avenue*
Des Moines, Iowa **50309**

Once we receive the form, the Wellmark Health Plan of Iowa, Inc., Enrollee Appeal Committee will review the complaint and issue a decision to you regarding the appeal within **30** calendar days if no additional information is required, or 40 calendar days if additional information is required. If we do not receive the requested additional information from you, we will make a decision.

FILING A SECOND LEVEL APPEAL

If you are not satisfied with the resolution of your complaint, you may appeal to the Enrollee

Appeal Committee of the Board. You must file the appeal within **30** calendar days of your receipt of our decision.

Appeals should be sent to:

Wellmark Health Plan of Iowa, Inc.
Enrollee Appeal Committee of the Board
Station 52
636 Grand Avenue
Des *Moines, Iowa 50309*

The Enrollee Appeal Committee of the Board will convene within **45** calendar days of receiving the appeal. We will notify you of the date **14** calendar days in advance of the meeting. You will have the opportunity to participate in this meeting either by phone or in person. The Enrollee Appeal Committee of the Board will issue a final decision and notify you by letter within five **(5)** business days of the meeting.

If you are dissatisfied with the process of resolving a complaint or appeal through Wellmark Blue Cross and Blue Shield of Iowa, you may contact the State of Iowa Insurance Commissioner.

Requests should be sent to:

State of Iowa Insurance Commissioner
Consumer and Legal Affairs
Insurance Division
Iowa Department of Commerce
330 East Maple Street
Des Moines, IA 50319

■ REVIEWING RECORDS

You can review records that deal with your request from 8:00 a.m. to 4:30 p.m., Monday through Friday, at our Des Moines location. Since so many of our records are electronically filed, please call in advance so we can have copies ready for you.

How much you pay for covered services is affected by your choice of provider. Generally, you will receive benefits *only* when you obtain health care services from or coordinated by your primary care provider (for circumstances in which you do not need to contact your primary care provider, see the **IMPORTANT INFORMATION** section).

This section covers:

- **Understanding Payment Vocabulary**
- **Understanding Amounts You Pay to Share Costs**

PAYMENT VOCABULARY

BENEFIT PERIOD

A benefit period is a period of 12 consecutive months that:

- *begins* on the effective date of the policyholder's coverage; and
- *ends* on the last day of the twelfth month after the effective date of coverage; and
- *renews* annually thereafter.

The benefit period is important for calculating your benefit period *maximums*.

BILLED CHARGE

The billed charge is the amount a provider bills for any services and supplies, whether or not the services or supplies are covered under this policy.

COVERED CHARGE

The covered charge is the amount a provider bills for services and supplies *covered* under this policy.

MAXIMUM ALLOWABLE FEE

The maximum allowable fee is an amount we establish, using various methodologies, for covered services and supplies. Our settlement amount will always be based on the lesser of the covered charge for a service or supply or the maximum allowable fee.

PAYMENT ARRANGEMENTS

We have contracting relationships with providers of health care services. We use different methods to determine payment arrangements, including negotiated fees. These payment arrangements usually result in savings, as described later in this section under *Payment Arrangement Savings.*

Payment Method for Services. Provider payment arrangements are calculated using industry methods, including but not limited to fee schedules, per diems, percentage of charge, per case, or negotiated fees. Some provider payment arrangements may include an amount payable to the provider based on the provider's performance. Performance-based amounts that are not distributed are not allocated to your specific group or to your specific claims and are not considered when determining any amounts you may owe. We reserve the right to change the methodology we use to calculate payment arrangements based on industry practice or business need. Participating providers agree to accept our payment arrangements as full settlement for providing covered services, except to the extent of any amounts you may owe.

Payment Arrangement Savings. The savings from payment arrangements and other important amounts will appear on your Explanation of Health Care Benefits statement as follows:

- *Provider Savings*, which reflects the amount saved on a claim due to our contracts with providers. For the majority of services, the

savings amount reflects the actual amount saved on a claim.

However, for some covered services, an estimated amount will be used based on the provider's yearly average savings percentage if the providers payment arrangement included retroactive settlements or incentive features. For some hospitals, we periodically estimate the total savings percentage we will earn and apply the amount of savings to our customers who receive services from that hospital. Changes in a hospital's savings percentage will not affect claims that have already been incurred. These changes will apply only to new claims. We review and make appropriate adjustments to this percentage every year upon renewal of each hospital's contract. For example, suppose our payment arrangement estimate is that we will save 20 percent off the covered charge for all inpatient services from hospital XYZ. That means that if you receive inpatient services from hospital XYZ, the payment arrangement amount would be based on the covered charge minus 20 percent. The following example shows how this works:

$1,000 (covered charge)
- 200 (savings percentage: 20% x 1,000)
$ 800 (payment arrangement amount)

Depending on many different factors, the amount we pay hospital ***XYZ*** could be more or less than the payment arrangement amount. Regardless of the amount we pay hospital *XYZ,* your payment responsibility will always be based on the payment arrangement amount.

- ***Contract Limitations,*** which reflects amounts for which you are responsible based on your contract with us. Examples of contract limitations are provided earlier in this policy in the IMPORTANT INFORMATION section.
- ***Our Settlement Amount,*** which reflects our responsibility to a provider. For some providers, this amount may not necessarily equal the amount we actually pay the provider. We determine our settlement amount by subtracting the following applicable amounts from the billed charge:
  - copayment.
  - provider savings.
  - contract limitations.

■ PREFERRED DRUG LIST

Often there is more than one medication available to treat the same medical condition. For that reason, we have developed ***The Preferred Drug List,*** sometimes known as a formulary, in cooperation with Advance Paradigm, our pharmacy benefits manager. This list is a comparison of prices among drugs that treat the same conditions. It is not a required list of medications. ***The Preferred Drug List*** is in your ***Wellmark Prescription Drug Guide.*** The list you have received is a representative sample of the most commonly prescribed drugs. For a description of the ***Wellmark Prescription Drug Guide,*** see the **GLOSSARY** at the end of this policy.

All participating providers have a copy of our ***Preferred Drug List.*** When your provider prescribes a drug for you, you can ask that he or she refer to the list's comparison of prices. Doing so can save you money and help control the costs of health care.

Drug Company Rebates. Drug manufacturers sometimes offer rebates to pharmacy benefits managers such as Advance Paradigm when the drugs they manufacture are used in preferred drug lists. Wellmark expects to receive a share of these rebates from Advance Paradigm. Any rebates we receive as a result of your prescription claims processed by Advance Paradigm will be retained by Wellmark and applied first to reduce the costs of administering the pharmacy program. The rebates will not be allocated to your specific group or to your specific claims and they will not be considered when determining your copayment amounts.

UNDERSTANDING AMOUNTS YOU PAY TO SHARE COSTS

■ COPAYMENT

Emergency Room Copayment is the amount you pay each time you visit a facility for emergency room services if your condition is not an *emergency,* as defined in the **GLOSSARY** at the end of this policy.

This copayment is waived if

- your condition is an *emergency,* as defined in the **GLOSSARY** at the end of this policy; *or*
- you are admitted as an inpatient immediately following emergency services; *or*
- you do not pay a premium to the third-party administrator.

This amount is shown on the **SUMMARY OF PAYMENT** at the beginning of this policy.

■ SERVICE LIMITATIONS

Certain covered services are subject to dollar or time limitations called *service limitations.* These limitations are shown on the **SUMMARY** OF **PAYMENT** at the beginning of this policy.

■ BENEFIT PERIOD MAXIMUM

The benefit period maximum is the maximum benefit each enrollee is eligible to receive for specific covered services during a benefit period. The benefit period maximum amount is reached from claims settled under this policy in a benefit period. Services subject to a benefit period maximum are shown on the **SUMMARY** OF **PAYMENT** at the beginning of this policy.

■ LIFETIME BENEFITS MAXIMUM

The lifetime benefits maximum is the amount each enrollee is eligible to receive for covered services in his or her lifetime. Lifetime benefits maximum amounts are accumulated from claims settled under this policy issued to you by Wellmark Health Plan of Iowa, Inc. This policy includes an overall lifetime benefits maximum which includes maximums for certain covered services. These amounts are shown on the **SUMMARY OF PAYMENT** at the beginning of this policy.

Once you receive health care services, we must receive a claim to determine the amount of your benefits. The claim lets us know what services you received, when you received them, and from which provider. Since Unity Choice Network providers file claims for you, you will only need to file a claim when you use a provider who is not in the Unity Choice Network.

This section explains:

- **The Claim Filing Process**
- **Filing When You Have Other Coverage**
- **Appealing a Denied Claim**

THE CLAIM FILING PROCESS

WHEN TO FILE YOUR CLAIM

After you receive health care services, you should only file a claim if your provider has not filed one for you. We must receive all claims within 365 days from the end of the year in which you received services.
If you need a claim form or have any questions after reading this section, please call us.

HOW TO FILE

Use a separate claim form for each member of your family and each provider. However, when filing itemized pharmacy statements for prescription drugs and medicines covered under this policy, you may attach receipts from more than one pharmacy to the claim form as long as the prescriptions are all for the same person.
Please note: Participating pharmacies electronically file claims for you.

Complete all Sections. You must complete all sections of the claim form. Directions are printed on the back of the form. You should keep a copy of the claim for your records because no part of it can be returned to you. You should follow the same procedure for filing a claim for services received in-state, out-of-state, or out-of-country.

Attach Copies. You must attach a copy of the itemized statement to the claim form. The statement must be a valid document from your provider. *(Statements you prepare, unitemized cash register receipts, receipt of payment notices, or balance due notices cannot be accepted.)* The itemized statements must be on the stationery of the provider who performed the service and must include the:

Provider's rubber stamp imprint with the provider's full name and address.
Patient's name.
Date(s) you received service(s).
Date of the injury or beginning of illness.
Charge for each service.
Description of each service.
Diagnosis or type of illness or injury.
Location where you received the service (office, outpatient, hospital, etc.).

We recommend that you attach statements to an 8.5" by 11" sheet of paper. Secure the statement(s) to the paper with tape (please do not use staples).

Sign the Claim. Make sure you sign the claim form. Please include a phone number where you can be reached during the day.

Send Your Claim to:
Wellmark Health Plan of Iowa, Inc.
636 Grand Avenue, Station 39
Des Moines, Iowa 50309-2565

Once we receive and process your claim, we will send you a statement explaining your benefits. This Explanation of Health Care Benefits statement tells you how we processed the claim.

Remember, if you receive covered services from a **Unity** Choice Network participating provider, we settle directly with that provider. You are responsible for paying any applicable amounts you may owe to your provider.

FILING WHEN YOU HAVE OTHER COVERAGE

■ COORDINATION OF BENEFITS

You may have other insurance or coverage that provides the same or similar benefit(s) as this policy. If so, we will work with your other insurance company or carrier. The benefits payable under this policy when combined with the benefits paid under your other coverage will not be more than 100 percent of either our payment arrangement amount or the other carrier's payment arrangement amount. ***Please note:*** The method we use to calculate our payment arrangement amount may be different than your other carrier's method. For a description of how we determine our payment arrangement amount, see *Payment Arrangements* in SECTION 4: YOUR PAYMENT OBLIGATIONS.

What You Should Do. When you receive services, you need to let us know that you have other coverage. Other coverage includes: group insurance; other group benefit plans (such as HMOs, PPOs, and self-insured programs); Medicare or other governmental benefits; and the medical benefits coverage in your automobile insurance (whether issued on a fault or no fault basis). To help us coordinate your benefits, you should:

- *inform* your provider by giving him or her information about your other coverage at the time you receive services. Your provider will pass the information on to us when the claim is filed.
- *indicate* that you have other coverage when you fill out a claim form by completing the appropriate boxes on the form. You will receive a letter from us if we need any additional information.

You must cooperate with us and provide requested information about your other coverage. If you do not give us necessary information, your claims may be denied.

What We Will Do. Once we have the information about your other coverage, we will contact your other insurance company or carrier and take care of the coordination of benefits for you. There are certain rules we follow to help us determine which policy pays first when you have other insurance or coverage that provides the same or similar benefits as this policy. Here are some of the rules:

- The coverage *without coordination of benefits* pays first when both coverages are through a group sponsor such as an employer, but one coverage has coordination of benefits and one does not.
- The medical benefits of your *auto coverage* will pay before this coverage if the auto coverage does not have a coordination of benefits provision that specifies it is secondary or excess to health insurance or health benefit plans.
- The coverage you have as *an employee* or plan enrollee pays before the coverage you have as a spouse or dependent child.
- The coverage you have as *the result of your active employment* pays before coverage you have as a retiree or under which you are not actively employed.
- The coverage with the *earliest continuous effective date* pays first when none of the above rules apply.

If none of these guidelines apply to your situation, we will use the coordination of benefits guidelines adopted by the Iowa Insurance Division to determine our settlement amount.

What You Should Know About Dependent Children. To coordinate benefits for a dependent child, the following rules apply. For a child who is:

- *covered by both parents* who are not separated or divorced, or if they are, neither parent has primary physical custody, the coverage of the parent whose birthday occurs first in a calendar year pays first. If another carrier does not use this rule, then the other plan will determine which coverage pays first.
- *covered by separated or divorced parents* and a court decree says which parent has financial or health insurance responsibility, that parent's coverage pays first.
- *covered by both separated or divorced parents* and a court decree does not stipulate which parent has financial or health insurance responsibility, the coverage of the parent with custody pays first. The payment order for such a dependent child is as follows: custodial parent, spouse of custodial parent, other parent, or spouse of other parent.

If none of these rules apply, the parent's coverage with the earliest continuous effective date pays first.

APPEALING A DENIED CLAIM

For information about appealing a denied claim, see *Appeal Process* in SECTION **3:** NOTIFICATION REQUIREMENTS.

Our responsibilities to you, as well as the conditions of your coverage with us, are defined in the documents that make up your **policy.** Your **policy includes this *benefits policy* and any *riders* or *amendments.***

This section will cover:

- **Coverage Eligibility**
- **Coverage Changes**
- **Coverage Termination**
- **Our Right to Recover Payments**
- **Other Information**

COVERAGE ELIGIBILITY

ELIGIBLE ENROLLEES

An eligible enrollee is determined by the third-party administrator.

TYPES OF COVERAGE

There is one type of coverage you may hold under this policy.

- With *single coverage,* the policyholder is the only one covered.

WHEN COVERAGE BEGINS

Your coverage under this policy begins on your effective date.

Please note: Before you receive benefits under this policy, you have agreed to release any necessary information requested about you so we can process claims for benefits. You must allow any provider, facility, or their employee to give us information about a treatment or condition. If we do not receive the information requested, your benefits may be denied.

If you fraudulently use your policy, then we may terminate this policy.

WHEN COVERAGE ENDS

Your eligibility for coverage will terminate the first day of the month for any of these reasons:

- You move from the service area.
- You reach age 19.
- You fail to pay the premium.
- You abandon Iowa residence. You will not be disenrolled if you are *temporarily* absent from the state.
- You become eligible for Medicaid.
- You become eligible for other health insurance coverage.
- You are admitted to a nonmedical public institution or an institution for mental disease unless temporary.
- You become an employee of the state of Iowa.

PREMIUMS

You must pay the third-party administrator in advance of the due date assigned for your policy. For example, payment must be made prior to the beginning of each calendar month, each quarter, or each year, depending on your specific due date.

COVERAGE CHANGES

EVENTS CHANGING COVERAGE

The following events should be reported to the third-party administrator:

- Decrease in income.
- Employment with the state of Iowa.
- Entry to a nonmedical public institution or admittance to an institution for mental disease.
- Iowa residence is abandoned.
- Medicare eligibility.
- Other insurance coverage.
- Pregnancy.

NOTIFICATION OF CHANGE

You must notify the third-party administrator as soon as possible but no later than 10 working days after the change.

COVERAGE TERMINATION

EFFECTS OF TERMINATION

If your policy is terminated for fraud, misrepresentation, or the concealment of material facts:

- we *will not pay* for any services or supplies provided after the date the policy is terminated.
- we *will retain legal rights.* This includes the right to initiate a civil action based on fraud, concealment, or misrepresentation.
- we *may,* at our option, *declare the policy void.*

If your policy is terminated for reasons other than fraud, concealment, or misrepresentation of material facts, we will stop benefits the day your policy is terminated.

An exception to this applies only when you receive benefits as an inpatient of a hospital or a resident of a nursing facility on the date the policy terminates. However, benefits for inpatient services are limited to the least amount of the following:

- **A** period equal to your *remaining days of coverage* under the policy.
- **A** period ending on *the date* **you** *are discharged* from the hospital or nursing facility.
- **A** period not more than 60 *days* from the date the policy is terminated.

OUR RIGHT TO RECOVER PAYMENTS

SUBROGATION

Once you receive benefits under this policy arising from an illness or injury, we will assume any legal right you have to collect compensation, damages, or any other payment related to the illness or injury, including benefits from any of the following:

- The responsible person's insurer.
- Uninsured motorist coverage.
- Underinsured motorist coverage.
- Other insurance coverage.

You agree to all of the following:

- **You** will let us know about any potential claims or rights of recovery related to the illness or injury.
- You will furnish any information and assistance that we determine we will need to enforce our rights under this policy.
- You will do nothing to prejudice our rights and interests.
- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without getting our written permission.
- You must reimburse us to the extent of benefit payments made under this policy if payment is received from the other party or parties.

You must notify us if you have the potential right to receive payment from someone else. You must cooperate with us to ensure that our rights to subrogation are protected.

We reserve the right to offset any amounts owed to us against any future claim settlement amounts.

PAYMENT IN ERROR

If for any reason we make payment under this policy in error, we may recover the amount we paid.

OTHER INFORMATION

ENROLLEE PARTICIPATION

You will be provided regular communication regarding matters such as wellness, general

health education, and matters of policy and operation of Wellmark Health Plan of Iowa, Inc.

NOTICE

If a specific address has not been provided elsewhere in this policy, you may send any notice to our home office:

Wellmark Health Plan of Iowa, Inc.
636 Grand Avenue
Des Moines, Iowa 50309-2565

Any notice from us to you is acceptable when sent to your address as it appears on our records or the address of the group through which you are enrolled.

CONFIDENTIALITY AND RELEASE OF INFORMATION

By using your identification card to receive any benefits to which you are entitled under this policy, you agree to the release to Wellmark Health Plan of Iowa, Inc., of any medical records reasonably related to your receipt of health care covered under this policy. This information will be used solely for legitimate business purposes including reports for regulatory authorities, annual health plan reports and/or for health plan accreditation purposes. Periodically, we will prepare reports for your primary care physician concerning your utilization of any services from another provider to better enable your primary care physician to assist you with your health care needs. Your identity will not be released in conjunction with such reports unless further written authorization is received from you. In the event that any law or regulation requires additional authorization for the release of your medical records, your cooperation in executing such further authorization(s) is a prerequisite for coverage of your claims.

NONASSIGNMENT

Benefits for covered services in this policy are for your personal benefit and cannot be transferred or assigned *to* anyone else without our consent. **Any** attempt to assign this policy or rights to payment without our consent will be void.

GOVERNING LAW

To the extent not superseded by the laws of the United States, this policy will be construed in accordance with and governed by the laws of the state of Iowa. Any action brought because of a claim under this policy will be litigated in the state or federal courts located in the state of Iowa and in no other.

LEGAL ACTION

No legal or equitable action may be brought against us because of a claim under this policy, or because of the alleged breach of this policy, more than two years after the end of the calendar year in which the services or supplies were provided.

Accidental Injury means an injury, independent of disease or bodily infirmity of any other cause, that happens by chance and requires immediate medical attention.

Admission is the formal acceptance of a patient into a hospital or other health care institution for a medical, surgical, or obstetrical condition.

Admission Review is an evaluation to determine the medical necessity of your admission into a hospital resulting from an emergency. The evaluation takes place when you or your provider notifies **us** of your admission by calling us. Once we are notified, we will determine if your condition warrants an inpatient admission or if your condition could be treated in some other setting. This type of review is typically carried out shortly after an emergency admission.

Advance Paradigm is our pharmacy benefits manager. Advance Paradigm owns the Advance Rx network, the network of participating pharmacies used by our managed drug programs.

Advanced Registered Nurse Practitioner (ARNP) means a registered nurse with advanced training in a specialty area who is registered with the Iowa Board of Nursing to practice in an advanced role. Specialty designations include: certified clinical nurse specialists, certified nurse midwives, certified nurse practitioners, and certified registered nurse anesthetists. **An** ARNP may provide care as an independent practitioner or in collaboration or consultation with a physician.

Agency or Program means an eligible provider of health services other than a facility, practitioner, or supplier. ***An*** example is a cardiac rehabilitation education program.

Ambulatory Surgical Facility provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient hospital bed.

Approved Services are those services and supplies covered under this policy.

Assisting Surgeon means a surgeon who is a medical doctor or a doctor of osteopathy.

Backup Provider refers to your primary care provider's designated backup who will treat you in the event your primary care provider is not available. The backup provider is in the Unity Choice Network and performs the same function as your primary care provider.

Benefit Period is a period of 12 consecutive months that:

- *begins* on the effective date of the policyholder's coverage; and
- *ends* on the last day of the twelfth month after the effective date of coverage; and
- *renews* annually thereafter.

Benefit Period Maximum is the maximum benefit each enrollee is eligible to receive for specific covered services during a benefit period.

Benefits means those medically necessary services and supplies that qualify for payment under this policy.

Better Beginnings® is a preconception and prenatal program for women who are planning for or expecting a baby.

Billed Charge is the amount a provider bills for any services and supplies, whether or not the services or supplies are covered under this policy.

BlueCard Program is the Blue Cross and Blue Shield Association program that permits members of any Blue Cross and/or Blue Shield Plan to have access to the advantages of

participating providers throughout the United States.

Blue Quality Center for Transplant is a facility that contracts with the Blue Cross and Blue Shield Association to perform specific transplants.

Braces include rigid and semi-rigid appliances and devices commonly used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. Braces do not include elastic stockings, elastic bandages, garter belts, arch supports, orthodontic devices or other similar items.

Chemical Dependency means a condition with physical or psychological symptoms produced by the habitual use of certain drugs as described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Revised,* (DSM-IV-R), or subsequent revisions to DSM-IV-R.

Community Mental Health Center provides outpatient treatment of mental health conditions.

Complications of Pregnancy means a cesarean section that was not planned, an ectopic pregnancy that is terminated, or a spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible. Complications of pregnancy also include conditions requiring inpatient hospital admission (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy.

Comprehensive Eye Examination includes a diagnostic ophthalmological examination, with refraction as medically indicated, initiation of treatment program, prescription of medication and lenses if indicated, post cyclopegic visit if required and verification of lenses if prescribed. The examination must be given by a physician.

Continued Stay Review is review of your care when you are in a facility or use home health services, hospice services, private duty nursing, or home infusion therapy. The review helps us to determine whether continuation of benefits at the current level is medically necessary.

Contract includes this benefits policy and any riders or amendments.

Contract Limitations are amounts that are your liability based on your contractual obligations with us. Examples of contractual limitations include services that are not covered, services that are not medically necessary, notification requirement penalties, and services that have reached contract maximums.

Contract Maximums are the maximum benefit amount enrollees are eligible to receive per service, benefit period, or lifetime for covered services.

Coordination of Benefits (COB) applies when you are covered by more than one group contract or commercial insurance policy providing benefits for like services. COB is a method of limiting insurance payment to no more than 100 percent of either our payment arrangement or the other carrier's payment arrangement.

Copayment is a fixed dollar amount you pay each time you receive certain covered services.

Covered Charge is the amount a provider bills for services and supplies covered under this policy.

Covered Services are those medically necessary procedures, services or supplies listed in this policy in **SECTION 1: BENEFITS.**

Diabetes (type I). Type I diabetes means that a person is insulin-dependent and requires insulin treatment for his or her lifetime.

Diabetes (type II). Type II diabetes means that a person is not insulin dependent but may manage his or her condition by diet, exercise, weight control, and in some instances, oral medications or insulin.

Diabetes Education Program is a state-approved, self-managed outpatient education program. The program helps a type I or type II diabetic and his or her family understand the diabetes disease process and the daily management of diabetes.

Effective Date is the date upon which this policy goes into effect.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in one of the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
- Serious impairment to bodily function; or Serious dysfunction of any bodily organ or part.

Emergency Admission is one that must take place immediately or disability or death may result.

Enrollee:

- for single coverage means the policyholder.

Enteral means an agent that is delivered through the digestive tract and absorbed naturally.

Explanation of Health Care Benefits is a statement you receive in the mail from us that outlines how we applied benefits to a submitted claim.

Facility is a licensed, certified, and/or accredited facility that provides inpatient and outpatient services. Examples of facilities are hospitals, nursing facilities, and ambulatory surgical facilities.

Facility to Treat Chemical Dependency is a licensed freestanding facility that is approved by us to provide treatment for chemical dependency conditions.

Formulary--%e *Preferred Drug List.*

Frame means a standard plastic eye-glass frame or similar frame into which two lenses are fitted.

Global Pricing Arrangements refers to an all-inclusive payment arrangement. This all inclusive payment arrangement bundles costs into one charge which includes all costs for hospitalization and physician fees.

Homebound means that, due to a physical or mental disability, you are unable to leave home other than for the purpose of obtaining medical care.

Home Health Agency (HHA) is a Medicare approved or Joint Commission for the Accreditation of Health Care Organizations (JCAHO)approved agency or organization that provides skilled nursing care in your home that lasts two hours or fewer.

Home Infusion Therapy means treatment provided in the home involving the administration of nutrients, antibiotics, and other drugs and fluids intravenously.

Home/Durable Medical Equipment is an item that meets the following criteria:

- It is durable enough to withstand repeated use.
- It is primarily and customarily manufactured to serve a medical purpose.
- It is not useful in the absence of illness or injury. Examples include wheelchairs, walkers, and crutches.

Hospice Program provides care in a comfortable setting (usually the home) for patients who are terminally ill and have a life expectancy of six months or fewer. Services include home health care plus respite services.

Hospice Respite Care is rest and relief help for the family caring for a terminally ill patient.

Hospital means an institution that provides for the diagnosis, treatment and care of injured or sick persons. The facility must be licensed as a hospital under applicable law.

Identification Card/BlueCard is the card issued to you by us. The information on the card, especially the identification number, is required to process your claims correctly and answer questions you may have. You should carry your identification card with you at all times and present it to your provider at the time you receive care, even when you receive services in a state other than Iowa.

Illness or Injury means any bodily disorder, bodily injury, disease or mental health condition and includes pregnancy and complications of pregnancy.

Immediate Family Member means your child, spouse, or parent.

Immunization is an injection with a specific antigen to promote antibody formation to make you immune to a disease or less susceptible to a contagious disease.

Individual Case Management is a provision which emphasizes the specialized care needs of patients with severe illnesses or injuries. Arrangements may be made to waive standard policy limitations to provide a more appropriate and comfortable setting for continued treatment.

Inpatient Admission is a stay in an inpatient facility (usually involving overnight care).

Investigational Treatment. You are not covered for services or supplies that are considered investigational or experimental. Treatment is considered investigational or experimental when the service, procedure, drug, or treatment has progressed to limited human application, but has not achieved recognition as being proven and effective in clinical medicine. Such recognition may be achieved through:

- final approval for use of a specific service, procedure, drug, or treatment for a specific diagnosis from the appropriate governmental regulatory body;
- scientific evidence permitting a consensus conclusion that recognizes the effectiveness of the specific service, procedure, drug, or treatment on health outcomes for a specific diagnosis.

We shall determine whether a service, procedure, drug, or treatment is investigational or experimental.

Lenses are ophthalmic corrective lenses ground as prescribed by a physician or optometrist to be fitted into a frame which meets the prescription standards and tolerances of the American National Standards Institute.

Lifetime Benefits Maximum is the maximum amount each member is eligible to receive for covered services in his or her lifetime. Lifetime maximum amounts are accumulated from claims settled under this policy issued to you by Wellmark Health Plan of Iowa, Inc.

Maximum Allowable Fee is an amount, using various methodologies, we establish for covered services and supplies.

Mechanical Organ is an organ that is implanted in the body and replaces the native organ.

Medicaid is a form of public assistance sponsored jointly by the federal and state governments providing medical assistance for eligible persons whose income falls below a certain level. This program is administered in Iowa by the Iowa Department of Human Services pursuant to Title XIX of the federal Social Security Act.

Medically Necessary means a covered procedure, service, or supply that we consider eligible for benefits under this policy. All covered services must be *medically necessary*. We decide what is medically necessary and our decision is final and conclusive. Even though your provider may recommend a procedure, service, or supply, the recommendation doesn't always mean the care is medically necessary. *Medically necessary* means those covered services that are all of the following:

- *Appropriate and necessary* for the symptoms, diagnosis, or treatment of your condition.
- *Provided for the diagnosis* or direct care and treatment of the condition and enabling you to make reasonable progress in treatment.
- *Within standards of professional practice* and given at the appropriate time and in the appropriate setting.
- *Not primarily for your convenience* or the convenience of your physician or other provider.
- *The most appropriate level of covered services* which can safely be provided.

Medicare (Title XVIII) is the federal government's health insurance program established under Title XVIII of the Social Security Act for people age *65* and older and for individuals of any age entitled to monthly disability benefits under the Social Security or Railroad Retirement Program. It is also for those with chronic renal disease who require hemodialysis or kidney transplant.

Mental Health Condition means a psychiatric, psychological, or emotional condition that satisfies all of the following criteria. The disorder is:

- not a chemical dependency condition (see the definition of *chemical dependency* earlier in this **GLOSSARY**); *and*
- classified as a mental health condition in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Revised (DSM-IV-R)* or subsequent revisions to DSM-IV-R; *and*
- listed only as a mental health condition in the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) or subsequent revisions to ICD-9-CM and not dually listed elsewhere in the ICD-9-CM.

Nonparticipating Facility is a facility that does not participate with a Blue Cross and Blue Shield Plan.

Nonparticipating Provider is a provider who does not participate with a Blue Cross and Blue Shield Plan.

Non-Unity Choice Network Facility is a facility that is not in the Unity Choice Network.

Non-Unity Choice Network Provider is a provider who is not in the Unity Choice Network.

Nursing Facility provides continuous skilled nursing services as ordered and certified by your attending physician. A registered nurse (R.N.) must supervise services and supplies on a 24-hour basis. A nursing facility must also be licensed under the laws of the state in which the facility is located.

Obstetrical/Gynecological (OB/GYN) Care Provider is your selected gynecological and

maternity health care manager. He or she will evaluate your condition and either treat your condition or coordinate gynecological or maternity services that you require.

Ophthalmologist is a physician specializing in the diagnosis and treatment of diseases and defects of the eye.

Optometrist specializes in the examination, diagnosis, treatment, and management of diseases and disorders of the visual system, the eye, and associated structures, as well as the diagnosis of related systemic conditions.

Oral Surgeon is a dentist licensed to perform diagnosis and treatment of oral conditions requiring surgical intervention.

Organ Procurement means hospital, physician, laboratory, administrative, and other miscellaneous costs related to the harvesting, preparation, preservation, and transportation of an organ for transplant. Organ procurement does not include fees for the purchase of an organ.

Other Providers means providers other than facilities and practitioners. Examples include hospice agencies, ambulance services, and retail pharmacies.

Our means Wellmark Health Plan of Iowa, Inc.

Out-of-Area Emergency is any emergency that occurs while you are outside of the Unity Choice Network Service Area.

Outpatient means care received in a practitioner's office, the home, or the outpatient department of a hospital or ambulatory surgery center.

Parenteral means an agent that is administered to the body by some other means than through the digestive tract. This includes injections given subcutaneously, intramuscularly, or intravenously.

Participating Facility participates with Wellmark Blue Cross and Blue Shield of Iowa or a Blue Cross and/or Blue Shield Plan in another state.

Participating Provider participates with Wellmark Blue Cross and Blue Shield of Iowa or a Blue Cross and/or Blue Shield Plan in another state.

Physician means a person licensed to practice medicine and surgery, osteopathic medicine and surgery, osteopathy, chiropractic, podiatry or optometry under the laws of this state.

Physician Assistant means a practitioner who is licensed by the Board of Physician Assistant Examiners to provide care under the supervision of a physician.

Planned Admission is an admission that can be scheduled in advance because the condition, illness, or injury is not immediately life-threatening.

Podiatrist is a specialist in conditions of the feet.

Policy includes any agreement or policy we have with you, this benefits policy, and any riders or amendments.

Policyholder is you, the enrollee, who has been certified by the Department as eligible for the HAWK-I program.

Postoperative Care is care given following a surgical operation.

Postpartum is the period of time following childbirth.

Practitioner means any individual recognized by us, licensed, and/or accredited to provide

covered services. Examples include certified nurse anesthetists, chiropractors, doctors of medicine and doctors of osteopathy, oral surgeons, physical therapists, and podiatrists.

Precertification is a process by which approval must be obtained before: a planned admission, use of home health services, private duty nursing, hospice services, or home infusion therapy. You must also precertify treatment of a mental health condition or chemical dependency.

Preferred Drug List is a comparative price listing of all medications available that treat the same medical condition.

Preoperative Care is care occurring, performed, or administered before and usually close to a surgical operation.

Preventive Care means select services provided to maintain the overall health of an enrollee.

Primary Care Provider (PCP) is your personal health care manager. He or she will evaluate your medical condition and either treat your condition or coordinate health care services that you require.

Prior Approval is a notification program for certain elective medical procedures. Receiving written prior approval will ensure you receive full benefits for certain procedures such as cosmetic surgery. If written prior approval is not received, we cannot confirm whether a proposed treatment plan is a benefit of this policy.

Private Duty Nursing means nursing services provided in your home by an approved registered nurse (R.N.) or a licensed practical nurse (L.P.N.) that last for extended periods of time.

Prosthetic Appliances are devices used as artificial substitutes to replace a missing natural part of the body and other devices to improve, aid, or increase the performance of a natural function. Prosthetic appliances do not include devices such as eyeglasses, hearing aids, orthopedic shoes, arch supports, orthotic devices, trusses, or examinations for their prescription or fitting.

Provider means a practitioner or facility.

Provider Savings means the amount saved due to our contracts with providers.

Psychologist means a provider who has a doctorate degree in psychology with **two** years clinical experience or who meets the standards of a national register.

Service Limitations are dollar or time limitations applied to certain services.

Settlement Amount is the amount that is discharged when your claim is processed.

Single Coverage means coverage for the policyholder only.

Spouse means your husband or wife as the result of a marriage that is legally recognized in Iowa.

Subrogation refers to our rights when you or your family members receive benefits of this policy required as the result of illness or injury and you have a lawful claim against another party or parties for compensation, damages, or other payment.

Supporting Service Provider is a provider who provides supporting services or ancillary services under the direction of your primary care provider or referral practitioner.

Termination Date is the date your coverage ends under this policy.

GLOSSARY

Unity Choice Network refers to a select panel of providers who have contracted with Wellmark Health Plan of Iowa, Inc., to provide services to those insured by the Unity Choice program.

Unity Choice Network Facility is a facility in the Unity Choice Network.

Unity Choice Network Provider is a provider in the Unity Choice Network.

Unity Choice Service Area includes communities in which we have participating providers and counties adjoining those counties.

Us means Wellmark Health Plan of Iowa, Inc.

We means Wellmark Health Plan of Iowa, Inc.

Well-child Care means care given to a child until he or she reaches age 19. Services include age-appropriate pediatric preventive services from birth until the child reaches age 19 as defined by current recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

You and Your means you, the policyholder.

Admission Review (see SECTION 3: NOTIFICATION REQUIREMENTS).

Your **Unity** Choice Network provider will handle notification requirements for you.

Appeal of denied or reduced benefits (see SECTION 3: NOTIFICATION REQUIREMENTS)

1-800-892-2397

— *or write within 120 calendar days*

Wellmark Health Plan of Iowa, Inc.
Enrollee Appeal Committee Station 52
636 Grand Avenue
Des Moines, Iowa 50309

Claims filing (see SECTION 5: FILING CLAIMS)

Wellmark Health Plan of Iowa, Inc.
636 Grand Avenue
Station 39
Des Moines, Iowa 50309

Changes, notification of (see SECTION 6: YOUR POLICY)

1-800-257-8563

Customer service

1-800-892-2397

Notices

— *change of coverage* (see SECTION 6: YOUR POLICY)

1-800-257-8563

— *ingeneral*

Wellmark Health Plan of Iowa, Inc.
636 Grand Avenue
Des Moines, Iowa 50309-2565

Precertification of services (see SECTION 3: NOTIFICATION REQUIREMENTS)

— Mental Health and Chemical Dependency
1-800-777-4295

— Other Inpatient Admissions, Home Health Services, Hospice Services, Private Duty Nursing, and Home Infusion Therapy -- Your primary care physician will handle notification requirements for you.

Prior approval of services (see SECTION 3: NOTIFICATION REQUIREMENTS)

Your primary care provider will request prior approval for you.

Website: www.wellmark.com